MIRS minimally invasive & ROBOTIC SURGERY

Arturo G. Gonzalez, MD, FACS
General Surgery

Patient Name: _____ Drivers Lic#_____

Address: _____ City/State/ Zip _____

Telephone:( )_____ Work: ( )_____ Cell:( )_____

Email Address: _____

Preferred Pharmacy Name/ Phone number: _____

Circle one: Employed full time/Part time Student Unemployed Retired

Circle one: Married Single Widowed

Patient

Employer/ School: _____

Address: _____

SS# _____

Date of Birth: _____

Spouse/ *Parent

Name: _____

Work #: _____

SS #: _____

Date of Birth: _____

* If the patient is a dependent child, please complete the information in the spouse section for the parent.

Emergency contact:

Name: _____ Relationship: _____

Address: _____ Phone #:_____

Insurance information

Primary Insurance

Ins Co: _____

Secondary Insurance

Ins Co: _____

Assignment of insurance benefits and authorization to release information

I authorize payment of medical benefits to Minimally Invasive & Robotic Surgery, PLLC for any and all services not paid in full at the time those services are rendered. I authorize to Minimally Invasive & Robotic Surgery, PLLC release any medical information as necessary for the completion of my insurance claims to any insurance carrier health or hospital plan. **Minimally Invasive & Robotic Surgery, PLLC does not accept any form of medicaid.**

Patient signature: _____ Date: _____

Patient's legal Guardian/ Agent: _____ Date: _____

New patient forms

Patient Name: _____

Reason for your visit: _____

Please list referring and current physicians

Physician name: _____ Area of specialty_____ consulting / referring

Physician name: _____ Area of specialty_____ consulting / referring

Physician name: _____ Area of specialty_____ consulting / referring

Past medical history- please circle all that apply.

Anemia	coronary heart disease	Hepatitis C	Weight loss
Anxiety	Crohn's disease	HIV/ AIDS	None of the above
Asthma	CVA- Stroke	Hyperlipidemia	
Atrial Fibrillation	Dementia	Hypertension	
Auto-Immune disease	Depression	Kidney disease	
Cirrhosis	Diabetes	Liver disease	
Allergies	Diabetic complications	Obesity	
Bleeding from stomach	Diverticulosis	Osteoarthritis	
Blood Transfusions	Deep vein thrombosis	Rheumatoid Arthritis	
Breast disease	Reflux disease (GERD)	Seizure Disorder	
Cancer	Gout	Substance Abuse	
Cerebrovascular disease	Heart Disease	Hyperthyroidism/ Hypothyroidism	
Chronic Renal Failure	Heart Attack	Tuberculosis	
COPD	Hepatitis A	Ulcers	
Congenital Heart disease	Hepatitis B	Vein Clotting	

Please list any medical conditions and the date of onset that are not listed above:

_____

_____

Review of symptoms: Please circle any symptoms you have experienced within the past 6 months.

Constitutional	**Eyes**	**Endocrine**	**Allergy/ immune**	**HENT**
Activity change Appetite Change Chills Diaphoresis Fatigue Fever Weight gain Weight loss Night Sweats None apply	Blurry vision Eye pain Eye redness Floaters Light flashes Sudden vision loss Eye discharge Visual disturbance None apply	Cold intolerance Heat intolerance Polydipsia Polyphagia Polyuria None apply	Environment allergies Food allergies Immunocompromised Recurrent infections None apply	Congestion Dental Problem Drooling Ear discharge Ear pain Ear redness Post nasal drip Rhinorrhea None apply
HENT cont.	**Respiratory**	**Genitourinary FEMALE**	**Genitourinary MALE**	**Neurological**
Scalp tenderness Sinus pain Sinus pressure Sneezing Sore throat Thrush Tinnitus Voice change None apply	Apnea Chest tightness Choking Cough Shortness of breath Stridor Wheezing None apply	Blood in urine Urinary frequency Hesitancy w/ urination Breast discoloration Breast lump Breast tenderness Hot flashes Nipple discharge Pelvic pain Pain during intercourse None apply	Blood in urine Frequency Erectile dysfunction Penile discharge Penile pain Penile swelling Scrotal swelling Testicular pain Urgency Urinary leakage None apply	Burning pain Cognitive difficulty Difficulty w/ balance Dizziness Facial asymmetry Fainting Headaches Light- headedness Memory loss Numbness None apply
Neurological cont.	**Cardiovascular**	**Hematologic**	**Gastrointestinal**	**Gastrointestinal cont.**
Seizures Speech difficulty Stroke Syncope Tremors Vertigo Weakness None apply	Chest pain Digital ulceration Irregular heartbeat Leg swelling Palpitations Pedal edema Varicose veins None apply	Adenopathy Bruises/ bleeds easily Clotting abnormality Petechial rash None apply	Abdominal distention Abdominal pain Anal bleeding Belching Cramping- Abdomen Constipation Diarrhea Difficulty swallowing Heartburn Hoarseness None apply	Mucous in stools Nausea Painful swallowing Rectal pain Regurgitation Stool leakage Ulcer Vomiting Vomiting blood None apply
Skin	**Musculoskeletal**	**Psychiatric**	**Psychiatric cont.**	**Others not listed:**
Acne Color change Dry skin Eczema Hair loss –axilla/ pubic Hair loss- scalp Pallor Photosensitivity Rash Sever itching Skin lesions Wound None apply	Achilles Tendonitis Back pain Double jointed Gait Problem Height loss Joint pain Joint swelling Joint warmth Muscle weakness Myalgias Neck pain Neck stiffness None apply	Agitation Behavior problem Confusion Daytime sleepiness Decreased concentration Depression Dysphoric mood Hallucinations None apply	Hyperactive Loss of pleasure Nervous/ anxious Sad mood Self- injury Sleep disturbance Suicidal ideas None apply	_____ _____ _____ _____ _____ _____ _____ _____

Past Surgical history- please list previous surgeries with date and facility where surgery was performed.

Date Where

1._____

2._____

3._____

Family history- Please list any conditions for your immediate family

Mother_____ Maternal Grandmother_____

Father_____ Maternal Grandfather_____

Sister_____ Paternal Grandmother _____

Brother_____ Paternal Grandfather_____

Other: _____

____ Family history unknown ____ Adopted

Social history

Marital status: Single _____Married _____ Widowed _____ Divorced

Tobacco use: __Current smoker Non Smoker Former smoker_____ exposed to smoke

If yes: Start date: Packs/day: _____ Quit date: _____years: _____

Smokeless tobacco: Never used Chew Snuff _____ Former user

Alcohol use: Never Yes No_____

Of Drinks per week:_____Glasses of wine_____ Cans of beer_____Shots of liquor_____Standard drinks_____

Drug use: _____Yes_____No_____Defer____Drug(s) preferred: _____

Please list any medication names, and dosages that you are on:

Medication name **Dosage/ Timing**

Do you have any allergies to medications? ____No _____ yes, if yes please list below with the reaction.

Medication: _____ Reaction_____

Medication: _____ Reaction_____

Medication: _____ Reaction_____